Commonwealth of Virginia
Department of Social Services

ADULT PROTECTIVE SERVICE REPORT

1. INTAKE

		FLIPS CODE	DATE OF REPORT	TIME OF REPORT
WORKER WHO TOOK CALL	ASSIGNED WORKER	CITY/COUNTY	DATE OF INTITAL RESPONSE	TIME OF INITIAL RESPONSE

NAME OF CLIENT (Last, First, Middle)				TELEPHONE NUMBER	SOCIAL SECURITY NUMBER
ADDRESS				DESCRIBE	
CITY, STATE, ZIP					
AGE	BIRTH DATE	RACE	SEX	DATE REPORT WRITTEN	TIME REPORT WRITTEN

WHERE THE INCIDENT OCCURRED	LIVING ARRANGEMENTS OF CLIENT	THE ABOVE ADULT WAS REPORTED TO BE
☐ PLACE OF RESIDENCE	☐ HOSPITAL ☐ GROUP HOME	☐ ABUSED ☐ NEGLECTED ☐ EXPLOITED
☐ HOSPITAL	☐ NURSING HOME ☐ WITH RELATIVE	ALLEGED SOURCE:
☐ DAY CARE FACILITY/HOME	☐ HOME FOR ADULTS SPECIFY:	☐ SELF ☐ INSTITUTIONAL
☐ COMMUNITY PROGRAM	☐ ALONE ☐ ELSEWHERE	☐ SPOUSE/RELATIVE /CARE GIVER
☐ OTHER:	☐ WITH SPOUSE SPECIFY:	☐ COMMUNITY PAID CARE GIVER
		☐ OTHER:

NAME OF COMPLAINANT	RELATIONSHIP / TITLE			
	☐	ANONYMOUS	☐	PRIVATE PHYSICIAN/NURSE
ADDRESS	☐	SELF	☐	DSS
	☐	FRIEND/NEIGHBOR	☐	RELATIVE
CITY, STATE, ZIP	☐	MH/MR STAFF	SPECIFY:	
	☐	CHURCH / CLERGY	☐	PUBLIC HEALTH DEPT.
TELEPHONE NUMBER	☐	AREA AGENCY ON AGING	☐	COMPANION PROVIDER
	☐	LAW WNFORCEMENT	☐	OTHER
INTERESTED PERSONS OR AGENCIES	☐	HOSPITAL / CLINIC	SPECIFY:	

NAME	ADDRESS	RELATIONSHIP	WITNESS	YES	NO
				☐	☐
				☐	☐
				☐	☐
				☐	☐

MEDICAL INFORMATION	NAMES OF PHYSICIANS (IF KNOWN)
DESCRIPTION OF MEDICAL PROBLEMS:	

COMPLAINANT DESCRIPTION OF SITUATION

COMPLAINANT IS A MANDATED REPORTER:	☐	YES	☐	NO	REPORT IS VALID:	☐	YES	☐ NO
PREVIOUS FOUNDED INCIDENT INVOLVING CLIENT:	☐	YES	☐	NO				
EMERGENCY:	☐	YES	☐	NO	CASE NUMBER:			
					APS CASE STATUS:	☐	OPEN	☐ CLOSED

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II. FOLLOW-UP

DATE APS VACIS SUPPLEMENT COMPLETED:					
FACE TO FACE INTERVIEW WITH CLIENT COMPLETED:	☐	YES	☐	NO	
IF NO EXPLAIN:					

COLLATERAL CONTACTS WITH:

RELATIVES			☐	NEIGHBORS/FRIENDS	
			☐	COMMUNITY SERVICES BOARD	
☐	AREA AGENCY ON AGING		☐	LOCAL HEALTH DEPT.	
☐	DSS LICENSING		☐	HEALTH CARE AGENCY	
☐	PHYSICIAN		☐	LAW ENFORCEMENT	
☐	CITY/COMMONWEALTH ATTORNEY				
☐	OTHER (SPECIFY)				

INVESTIGATIVE FINDINGS

COMMENTS (URRENT SITUATION COMPETENCE OF CLIENT, ETC)

DISPOSITION		PETITION (CHECK ONE)			
☐	UNFOUNDED	☐	NOT NECESSARY		
☐	NEED FOR P.S. NO LONGER EXIST	☐	NECESSARY (CHECK TYPE OF PETITION)	☐	COMMITMENT TO STATE OR PRIVATE HOSPITAL
☐	NEEDS PROTECTIVE SERVICES	☐	EMERGENCY	☐	PROTECTION ORDER
☐	SERVICES ACCEPTED	☐	ORDER FOR MEDICAL TREATMENT	☐	OTHER (SPECIFY)
☐	SERVICES NOT ACCEPTED	☐	GUARDIANSHIP/COMMITTEE	DSS INITIATED ☐	YES ☐ NO

SERVICE NEEDS INDENTIFIED (ITEMIZE SERVICES)	ACCEPTED	REFUSED	NOT AVAILABLE
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

COMPLAINANT NOTIFIED THAT INVESTIGATION WAS CONDUCTED			☐	VERBALLY	☐ IN WRITING
DATE OF NOTIFICATION:					
THIS WAS A JOINT INVESTIGATION	☐	YES	☐	NO	
WITH	☐	DSS LICENSING			
	☐	OMBUDSMEN			
	☐	MH/MP			
	☐	STATE HEALTH LICENSING			
	☐	LAW ENFORCEMENT			
	☐	OTHER (SPECIFY)			